

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4651AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/25/2009
NAME OF PROVIDER OR SUPPLIER CANYON HILLS MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 10125 CANYON HILLS AVE LAS VEGAS, NV 89148		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 6/25/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for five Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was five. Five resident medication records were reviewed. Complaint #NV00022176 was substantiated. See Tags Y103 and Y895. An additional regulatory deficiency was also identified.	Y 000		
Y 108 SS=F	449.200(3) Per File - Storage & Availability NAC 449. 200 3. The administrator may keep the personnel files for the facility in a locked cabinet and may, except as otherwise provided in this subsection, restrict access to this cabinet by other employees of the facility. Copies of the documents which are evidence that an employee has been certified to perform first aid and cardiopulmonary resuscitation and that the employee has been tested for	Y 108		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4651AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/25/2009
NAME OF PROVIDER OR SUPPLIER CANYON HILLS MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 10125 CANYON HILLS AVE LAS VEGAS, NV 89148		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 920	<p>Continued From page 3</p> <p>locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key.</p> <p>This Regulation is not met as evidenced by: Based on observation on 6/25/09, the facility did not ensure the location where medications for 5 of 5 residents were stored remained locked when not being used by the caregiver (Resident #1, #2, #3, #4 and #5).</p> <p>Severity: 2 Scope: 3</p>	Y 920			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.